Impact of the Affordable Care Act on Ryan White Programs

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Areas for Discussion

- Introduction
- Impact of the Affordable Care Act
- ACA Already in Effect
- Effect of the Affordable Care Act on Ryan White Programs

Impact of the Affordable Care Act

BPHC and HAB Emphasis on Fee for Service not Grants

- Medicaid in the year 2014
- Medicare True Out of Pocket Costs (TrOOP)
- State and Federal PCIP
  - Pre-existing Condition Insurance Plans
  - Evolve Into Health Care Exchanges in 2012
    - Reimburse at FQHC Rate
- ADAP and Insurance Assistance Programs

Changes in Medicare TrOOP Rules

- Effective January 1, 2011 – ADAP Programs are allowed to pay the True Out of Pocket Costs for Medicare patients with federal funds.
    - Patients will now exit the Medicare “donut hole” and have Part D Pharmacy benefits.
    - ADAP Programs will save 50% or more of the cost of ARV medications for patients that have Medicare Part D

State and Federal PCIPs

- The Affordable Care Act requires every state to either create a PCIP (Pre-existing Condition Insurance Plan) or to participate in a federally operated plan.

- To be eligible a patient must have been without insurance for at least 6 months and have been turned down by a commercial insurance company.

  - PCIP – Insurance Premiums were reduced dramatically effective July 1, 2011. Federal PCIP health insurance is available for between $220 to $550 per month.
  - Variables - Patient Age, Sex and Income

Medicaid in the year 2014

- All persons with incomes below 133% of the federal poverty level (FPL) will be eligible for Medicaid in 2014.
- Several states have already implemented the 133% eligibility standard.
  - How many of your clients will have Medicaid?
  - How much does Medicaid Reimburse in CT?
  - Can you survive on Medicaid reimbursement?
  - Have you thought about FQHC status?

ADAP and Insurance Assistance Programs

- ADAP is changing from a medication program that direct purchases medications to a program that pays health insurance premiums, co-pays and deductibles for persons with HIV.
  - Savings of an average of $8,000 per year on medications
  - Savings on payments for costly laboratory procedures.
  - Savings on other medical costs: specialty care, ancillary services and non-HIV related health care needs of patients.
  - Ability to collect rebates from pharmaceutical manufacturers related to 340B discounts from the partial payment of medication co-pays and deductibles.

Effect of Affordable Care Act on Ryan White Programs.

- Ryan White Part A and Part B Programs will still exist
  - Too many gaps in health insurance and medication programs
  - RW services will still need the array of services that are not paid for by health insurance.
- Ryan White Part A and Part B Programs will become more focused on Program Income for clinical services.
- ASOs and Part C Programs will need to become experts at billing and collection to survive in the new HIV services environment.

Impact of ACA on RW Part B

- RW Part B and ADAP Focus on Health Insurance Assistance
- Payment of Premiums – Co-pays and Deductibles
  - Coverage for Medications
  - Coverage for Primary Care
  - Need for a PBM
- Other Billable Services –
  - Medical Home Model
  - Health Home Model

Changes to ADAP

ADAP – Transition from Purchasing Medications

Insurance Assistance Program – Case Managers – Oversee health insurance benefit program.

Impact of ACA on Case Managers

1. Evaluation and Enrollment of as many clients as possible in IAP.

   Training by Kentucky Part B Office

2. Working knowledge of COBRA, PCIP, Health Care Exchanges, Private Health Insurance, Medicare , Medicare Part D, Medicaid.

   Training by Kentucky Part B Office

3. Working knowledge of insurance networks, insurance benefits, prior approvals for services.
4. Ability to work with insurance company benefit managers to overcome denials for medications and health care services.

Impact on Kentucky Part B Subgrantee Budgets

- Every Part B Contractor has funding to pay for health insurance premiums to assist the IAP Program
- Insufficient Funding in the current budgets to meet the need to increase IAP enrollment.
- ADAP will transfer funds from ADAP to IAP – to facilitate the enrollment of more patients in IAP and to save money for the ADAP Program
- Projections
  - Number of Clients
  - Cost Per Client
    - Medicare Part D
    - PCIP/Exchange
    - Private Insurance

Subgrantees Taking Advantage of ACA – New World

70% to 90% of Patients will be Insured

- New Billable Services
  - Primary Care
  - Medical Case Management
    - Medical Home Model
    - Health Home Model
- FQHC and FQHC Lookalike Status
- 340 B Programs

FQHC and FQHC Look-Alike Status

- Federally Qualified Health Centers

  Automatically Designated as FQHCs

  - Community Health Centers
  - Healthcare for the Homeless Programs
  - Migrant Health Centers

- FQHC Look-Alikes – Public and private non-profit health care organizations may apply to become a FQHC Look-Alike at any time.
  - FQHC Look-Alikes must meet the same program requirements as FQHCs that receive Federal funding and are eligible for many of the same benefits.

FQHC and FQHC Look-Alike Comparison

	Section 330 Health Centers	FQHC Look-Alike
• Competitive application process	YES	NO
• Receive direct funding from Federal government	YES	NO
• Located in medically underserved area	YES	YES
• Provide services based on ability to pay	YES	YES
• At least 51 percent of governing board members represent active users of the health center	YES	YES
• Enhanced Medicaid/Medicare reimbursement	YES	YES
• FTCA coverage	YES	NO
• 340B drug pricing program	YES	YES

FQHC Benefits

- Federal Financial Support via a HRSA Grant
- FQHC Cost Based Reimbursement – PPS Rate
- 340B Medications – Covered Entity
- Federal Tort Claims Administration Malpractice Coverage
- Federal Loan Guarantee Program
- Access to recruitment of providers through National Health Service Corp and J-1 Visa Program

FQHC Look-Alike Program Benefits

- Cost Based/PPS Reimbursement
- 340B Medications – Covered Entity
- Access to recruitment of providers through National Health Service Corp and J-1 Visa Program

Drawbacks to Becoming and FQHC

- Change in Mission – No longer only a HIV dedicated provider of services
- Change in Users of Services – Must provide primary care services to all persons that are eligible that present for care.
- Change in Board of Directors – 51% of board must be consumers of services. Board membership must have the same racial and gender composition as the users of the health center.
  - Affects Fundraising
- Federal Reporting – UDS Reports

Getting Started

- Bureau of Primary Care (BPHC) – 2009 Guidance
  - http://bphc.hrsa.gov/policiesregulations/policies/pin200906.html
- Bureau of Primary Care (BPHC) - Website
  - http://www.bphc.hrsa.gov/policiesregulations/policies/fqhclookalikes.html

Developing a 340B Pharmacy

- The “340B Program” was established by Section 602 of the Veterans Health Care Act of 1992 (P.L. 102-585), which put Section 340B of the Public Health Service Act into place. Sometimes referred to as “PHS Pricing” or “602 Pricing,” the 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to certain covered entities specified in the statute 42 U.S.C. 340B(a)(4) at a reduced price, also defined in the statute.

Benefits of Operating a 340B Pharmacy

- Patient Benefits
  - Convenient access to ARV medications
  - Reliable advice on adverse reactions and counter-indications. From pharmacy staff that is knowledgeable regarding ARV medications.
  - Sliding-fee discounts for co-pays and deductibles
  - Flexibility to change ARV medication regimens

Pharmacy Models

- Direct operations – Part A or C Clinic hires pharmacist and staff and operates a pharmacy – 100% of the risk of making money is on the clinic. All start-up funds for the pharmacy, medications and staff are the responsibility of the clinic

- Subcontract model – onsite or offsite, Less risk. The clinic either leases space to an outside pharmacy or contracts with an outside pharmacy to operate the 340B pharmacy. Less profit.

- Subcontract model – mail order – Less risk, lower costing, patients do not have to come to the clinic or the pharmacy to get their meds. Often increases patient confidentiality.

Negotiation of Rates with Subcontract Pharmacies

- Percentage of Net Revenue – Generally this method is based on taking the total revenue after the cost of the 340B Medications and splitting the revenue on a percentage basis. Sometimes 50% Sometimes 25%
  - This method usually results in the pharmacy being drastically overpaid.
- Dispensing Fees – paid on a per prescription basis. Usually higher than the dispensing fee that would be charged for non ARV medications.
  - This method is better for the RW Part A or C Clinic.

Getting Started

- Article on Developing a 340B Pharmacy
  - http://nyshealthfoundation.org/uploads/resources/pharmacy-services-community-health-center-case-study-march-2012.pdf
- HRSA 340B Website
  - http://www.hrsa.gov/opa/introduction.htm
- Office of Pharmacy Affairs - Covered Entity Registration
  - http://opanet.hrsa.gov/opa/default.aspx
- Prime Vendor Program Website
  - http://www.hrsa.gov/opa/primevendor.htm

Thank you

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